		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037929

Facility Name: Lakewood Center

Address: 1112 North Eastern Avenue (Number) Plainfield (City) 60544 (Zip Code)

County: Will

Telephone Number: (815) 436-3400 **Fax #** (815) 436-1357

IDPA ID Number: 22-3152459001

Date of Initial License for Current Owners: 05/01/92

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Laura Hillenbrand **Telephone Number:** (304) 599-0395

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Sonia Bailey-Gibson
(Title) Senior VP of Operations

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,794	15,661	5,643	32,098	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,794	15,661	5,643	32,098	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.56%

D. How many bed-hold days during this year were paid by Public Aid?
92 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/92

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 93 and days of care provided 5,457

Medicare Intermediary Riverbend Goverment Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	204,532	16,360	34,677	255,569	1,039	256,608	(1)	256,607			1
2	Food Purchase		130,674		130,674		130,674	(672)	130,002			2
3	Housekeeping	107,905	12,246	4,824	124,975	24	124,999		124,999			3
4	Laundry	20,829	13,521	31,707	66,057	199	66,256		66,256			4
5	Heat and Other Utilities			84,784	84,784		84,784		84,784			5
6	Maintenance	50,617	16,037	37,748	104,402	(266)	104,136		104,136			6
7	Other (specify):* Trash Removal			18,860	18,860		18,860		18,860			7
8	**TOTAL General Services**	383,883	188,838	212,600	785,321	996	786,317	(673)	785,644			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,797,798	167,629	(5,785)	1,959,642	(3,455)	1,956,187	21,788	1,977,975			10
10a	Therapy		2,069	382,441	384,510		384,510	(31,923)	352,587			10a
11	Activities	54,112	7,463	8,579	70,154	(570)	69,584	(2,053)	67,531			11
12	Social Services	85,931		248	86,179	1,104	87,283		87,283			12
13	Nurse Aide Training			1,050	1,050	(1,050)						13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,937,841	177,161	394,933	2,509,935	(3,971)	2,505,964	(12,188)	2,493,776			16
	C. General Administration											
17	Administrative	146,832	1,103	358,876	506,811	1,889	508,700	66,941	575,641			17
18	Directors Fees											18
19	Professional Services			625	625		625		625			19
20	Dues, Fees, Subscriptions & Promotions			5,400	5,400	1,748	7,148	(446)	6,702			20
21	Clerical & General Office Expenses		20,091	47,190	67,281	(500)	66,781	98	66,879			21
22	Employee Benefits & Payroll Taxes			473,524	473,524	(1,810)	471,714	(30)	471,684			22
23	Inservice Training & Education					1,103	1,103	(7)	1,096			23
24	Travel and Seminar			5,831	5,831	545	6,376		6,376			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,687	26,687		26,687		26,687			26
27	Other (specify):* Miscellaneous Exp			114,823	114,823		114,823	(114,166)	657			27
28	**TOTAL General Administration**	146,832	21,194	1,032,956	1,200,982	2,975	1,203,957	(47,610)	1,156,347			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,468,556	387,193	1,640,489	4,496,238		4,496,238	(60,471)	4,435,767			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lakewood Center #0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			24,121	24,121		24,121	137,380	161,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,038	3,038		3,038	161,415	164,453			32
33	Real Estate Taxes			63,602	63,602		63,602		63,602			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,859	29,859		29,859	(79)	29,780			35
36	Other (specify):*											36
37	**TOTAL Ownership**			120,620	120,620		120,620	298,716	419,336			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			5,086	5,086		5,086		5,086			38
39	Ancillary Service Centers			306,918	306,918		306,918	(2,170)	304,748			39
40	Barber and Beauty Shops			28,706	28,706		28,706		28,706			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,559	51,559		51,559		51,559			42
43	Other (specify):* **See Attached**			37,933	37,933		37,933		37,933			43
44	**TOTAL Special Cost Centers**			430,202	430,202		430,202	(2,170)	428,032			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,468,556	387,193	2,191,311	5,047,060		5,047,060	236,075	5,283,135			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(34)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,308)	10		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	56,221	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(631)	2		13
14	Non-Care Related Interest	(132)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,983)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(104,450)	27		24
25	Fund Raising, Advertising and Promotional	(7,733)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (64,050)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	275,219		34
35	Other- Attach Schedule	24,906		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 300,125		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 236,075		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lakewood Center

ID# 0037929

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cable TV Expense	$ (2,053)	11	1
2	PAC Dues	(446)	20	2
3	Add on Contract Nrsg	27,405	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	24,906		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(1)	0	0	0	0	0	0	0	0	0	(1)	1
2	Food Purchase	(665)	(7)	0	0	0	0	0	0	0	0	0	(672)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(665)	(8)	0	0	0	0	0	0	0	0	0	(673)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	22,097	(282)	(27)	0	0	0	0	0	0	0	0	21,788	10
10a	Therapy	0	(31,923)	0	0	0	0	0	0	0	0	0	(31,923)	10a
11	Activities	(2,053)	0	0	0	0	0	0	0	0	0	0	(2,053)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	20,044	(32,205)	(27)	0	0	0	0	0	0	0	0	(12,188)	16
	C. General Administration													
17	Administrative	0	66,941	0	0	0	0	0	0	0	0	0	66,941	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(446)	0	0	0	0	0	0	0	0	0	0	(446)	20
21	Clerical & General Office Expenses	0	98	0	0	0	0	0	0	0	0	0	98	21
22	Employee Benefits & Payroll Taxes	0	(30)	0	0	0	0	0	0	0	0	0	(30)	22
23	Inservice Training & Education	0	0	(7)	0	0	0	0	0	0	0	0	(7)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(114,166)	0	0	0	0	0	0	0	0	0	0	(114,166)	27
28	**TOTAL General Administration**	(114,612)	67,009	(7)	0	0	0	0	0	0	0	0	(47,610)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,233)	34,796	(34)	0	0	0	0	0	0	0	0	(60,471)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Center # 0037929 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	56,221	81,159	0	0	0	0	0	0	0	0	0	137,380	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(132)	161,547	0	0	0	0	0	0	0	0	0	161,415	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(45)	(34)	0	0	0	0	0	0	0	0	(79)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	56,089	242,661	(34)	0	0	0	0	0	0	0	0	298,716	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(2,170)	0	0	0	0	0	0	0	0	0	(2,170)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(2,170)	0	0	0	0	0	0	0	0	0	(2,170)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(39,144)	275,287	(68)	0	0	0	0	0	0	0	0	236,075	45

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Genesis Health Ventures	100	See Attached List		LWNR, Inc.	Hackensack, NJ	Property Owner
				Neighborcare	Willowbrook, IL	Pharmacy
				Genesis Rehab	Kennett Square, PA	Therapy
				Genesis Hosptiality	Kennett Square, PA	Dietary
				Genesis Staffing	Kennett Square, PA	Staffing
				Respiratory Health	Kennett Square, PA	Respiratory

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	LWNR, Inc.		$ 81,159	$ 81,159	1
2	V	21	Quarterly & Annual Reports		LWNR, Inc.		100	100	2
3	V	32	Interest	3,038	Genesis Health Ventures	100.00%	164,585	161,547	3
4	V	17	Administrative	358,876	Genesis Health Ventures	100.00%	425,817	66,941	4
5	V	1	Related Party Mark-Up	1	Neighborcare			(1)	5
6	V	2	Related Party Mark-Up	7	Neighborcare			(7)	6
7	V	10	Related Party Mark-Up	282	Neighborcare			(282)	7
8	V	21	Related Party Mark-Up	2	Neighborcare			(2)	8
9	V	22	Related Party Mark-Up	30	Neighborcare			(30)	9
10	V	35	Related Party Mark-Up	45	Neighborcare			(45)	10
11	V	39	Related Party Mark-Up	2,170	Neighborcare			(2,170)	11
12	V	10a	Related Party Mark-Up	13	Neighborcare			(13)	12
13	V	10a	Related Party Mark-Up	31,910	Genesis Rehab			(31,910)	13
14	Total			$ 396,374			$ 671,661	$ * 275,287	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		10	Related Party Mark-Up	$ 27	Respiratory Health		$	$ (27)	15
16	V		35	Related Party Mark-Up	34	Respiratory Health			(34)	16
17	V		23	Related Party Mark-Up	7	Neighborcare			(7)	17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 68			$ 0	$ * (68)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Facility is owned by a publicly traded company.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Genesis Health Ventures
Street Address: 101 E. State Street
City / State / Zip Code: Kennett Square, PA 19348
Phone Number: (610) 925-4076
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Costs		373	$ 140,141,312	$		$ 425,817	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 140,141,312	$		$ 425,817	25

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mellon Bank Revolving Credit		X				$ 2,484,681	$ 2,484,681		6.6300	$ 164,585	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,484,681	$ 2,484,681			$ 164,585	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,484,681	$ 2,484,681			$ 164,585	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 52,662	2
3. Under or (over) accrual (line 2 minus line 1).		$ 52,662	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,939	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 63,601	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	13,730	8
	1998	13,481	9
	1999	49,663	10
	2000	51,450	11
	2001	52,662	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0037929

CONTACT PERSON REGARDING THIS REPORT Laura Hillenbrand

TELEPHONE 304-599-0395 FAX #: 304-285-0624

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-10-312-003-0000	Long Term Care	$ 52,662.34	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,662.34	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,925 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	273,121	1992	$ 20,000	1
2					2
3	TOTALS	273,121		$ 20,000	3

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	50		1992	1971	$ 500,000	$	30	$ 16,667	$ 16,667	$ 177,779	4
5	43			1999	3,543,134	81,159	35	101,232	20,073	320,538	5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	27,756		20	1,391	1,391	12,885	9
10	Leasehold Improvements			1994	88,634		20	4,432	4,432	37,670	10
11	Leasehold Improvements			1995	6,745		20	321	321	2,420	11
12	Leasehold Improvements			1997	4,015		20	181	181	1,042	12
13	Leasehold Improvements			1997	1,550		35	40	40	203	13
14	Leasehold Improvements			1998	1,018		35	24	24	120	14
15	Plumbing & Heating			1999	725		35	21	21	84	15
16	Conduit & wiring for sanitizer			1999	918		35	26	26	104	16
17	Annual test on generator			1999	1,430		35	41	41	164	17
18	Generator pad replacement			1999	3,688		35	105	105	420	18
19	Dampers			1999	542		35	15	15	60	19
20	Smoke detector panels			1999	961		35	27	27	108	20
21	Stripper & floor finish			1999	798		35	23	23	92	21
22	Fix phone line			1999	338		35	10	10	40	22
23	Service alarm system			1999	468		35	13	13	52	23
24	Electric			1999	663		35	19	19	76	24
25	Install conduit & wiring for outlets			1999	1,316		35	38	38	152	25
26	Concrete sealer			1999	922		35	26	26	104	26
27	Fire sprinkler system			1999	430		35	12	12	48	27
28	Exit alarms			1999	521		35	15	15	60	28
29	Picket fence			2000	1,328		35	38	38	114	29
30	New wing			2000	9,624		35	275	275	825	30
31	Exit alarms (4)			2001	476		35	14	14	28	31
32	Butterfly dampers			2001	375		35	11	11	22	32
33	Propane			2001	605		35	17	17	34	33
34	Waste removal			2001	3,936		35	112	112	224	34
35	Management of renovation			2001	48,000		35	1,371	1,371	2,742	35
36	Mobile kitchen			2001	59,949		35	1,713	1,713	3,426	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Construction supervision	2001	$ 38,570	$	35	$ 1,102	$ 1,102	$ 2,204	37
38	Demolition	2001	9,461		35	270	270	540	38
39	Paving	2001	2,500		35	71	71	142	39
40	Excavation	2001	2,225		35	64	64	128	40
41	Concrete	2001	7,077		35	202	202	404	41
42	Masonry	2001	1,500		35	43	43	86	42
43	Steel	2001	3,087		35	88	88	176	43
44	Carpentry	2001	25,822		35	738	738	1,476	44
45	Misc Materials	2001	10,000		35	286	286	572	45
46	Doors	2001	5,743		35	164	164	328	46
47	Drywall	2001	12,380		35	354	354	708	47
48	Flooring	2001	14,315		35	409	409	818	48
49	Painting	2001	852		35	24	24	48	49
50	Plaster	2001	8,560		35	245	245	490	50
51	HVAC	2001	35,285		35	1,008	1,008	2,016	51
52	Fire protection	2001	6,365		35	182	182	364	52
53	Plumbing	2001	33,899		35	969	969	1,938	53
54	Electrical	2001	41,457		35	1,184	1,184	2,368	54
55	Kitchen equipment	2001	15,316		35	438	438	876	55
56	Overhead/profit	2001	42,775		35	1,222	1,222	2,444	56
57	Change order	2001	10,874		35	311	311	622	57
58	Architect fees	2001	12,288		35	351	351	702	58
59	Other kitchen costs	2001	10,947		35	313	313	626	59
60	Door Alarm Upgrade / Repair	2002	6,873	627	7	654	27	654	60
61	2 Exit Doors	2002	2,759	133	7	197	64	197	61
62	New Ceiling Installation	2002	7,782	248	7	371	123	371	62
63	Carpet & Tile for LR, DR and Hall	2002	4,956		20	21	21	21	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,684,533	$ 82,167		$ 139,511	$ 57,344	$ 582,955	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 150,690	$ 21,931	$ 20,808	$ (1,123)	7	$ 77,291	71
72	Current Year Purchases	14,305	1,183	1,183		5-7	1,183	72
73	Fully Depreciated Assets	231,887					231,887	73
74								74
75	TOTALS	$ 396,882	$ 23,114	$ 21,991	$ (1,123)		$ 310,361	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,101,415	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,281	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 161,502	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 56,221	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 893,316	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 29,859 Description: Admin $3835, Ancillary $4253, Nrsg $21,770
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 2&3	hrs	$	2,631	$ 148,450	$ 533	2,631	$ 148,983	1
2	Licensed Speech and Language Development Therapist	10a, 2&3	hrs		861	46,753	77	861	46,830	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2&3	hrs		3,153	187,238	1,459	3,153	188,697	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				305,779		305,779	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	6,645	$ 382,441	$ 307,848	6,645	$ 690,289	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lakewood Center **#** 0037929 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 122,980	$ 122,980	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	671,522	671,522	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,221	5,221	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 799,723	$ 799,723	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,065	393,479	13
14	Buildings, at Historical Cost	15,498	3,478,304	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	175,936	175,936	16
17	Accumulated Depreciation (book methods)	(31,777)	(139,989)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	11,873	11,873	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 174,595	$ 3,919,603	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 974,318	$ 4,719,326	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,183	$ 79,183	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	202,100	202,100	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,977	36,977	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 318,260	$ 318,260	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Due to Related Party	(118,519)	3,799,964	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (118,519)	$ 3,799,964	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 199,741	$ 4,118,224	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 774,577	$ 601,102	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 974,318	$ 4,719,326	48

***(See instructions.)**

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,744,105	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,744,105	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	521,265	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Fresh Start - Bankruptcy Entry**	(2,521,159)	15
16	Other (describe) **Depreciation Adjustment**	30,366	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,969,528)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 774,577	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,122,084	1
2	Discounts and Allowances for all Levels	224,509	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,346,593	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	614,928	6
7	Oxygen	611	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 615,539	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	32,967	13
14	Non-Patient Meals	34	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	303,391	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,254	19
20	Radiology and X-Ray	16,551	20
21	Other Medical Services	209,496	21
22	Laundry	20,273	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 614,966	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	132	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 132	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(8,905)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (8,905)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,568,325	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	785,321	31
32	Health Care	2,509,935	32
33	General Administration	1,200,982	33
	B. Capital Expense		
34	Ownership	120,620	34
	C. Ancillary Expense		
35	Special Cost Centers	378,643	35
36	Provider Participation Fee	51,559	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,047,060	40
41	**Income before Income Taxes (line 30 minus line 40)****	521,265	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 521,265	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,938	2,124	$ 62,381	$ 29.37	1
2	Assistant Director of Nursing	1,852	2,048	48,795	23.83	2
3	Registered Nurses	16,881	17,994	427,673	23.77	3
4	Licensed Practical Nurses	15,922	16,831	346,193	20.57	4
5	Nurse Aides & Orderlies	65,134	71,303	872,361	12.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,503	4,955	53,542	10.81	10
11	Social Service Workers	4,257	4,779	87,035	18.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,661	20,202	205,572	10.18	15
16	Dishwashers					16
17	Maintenance Workers	3,254	3,549	50,352	14.19	17
18	Housekeepers	10,688	11,896	107,929	9.07	18
19	Laundry	2,183	2,480	21,028	8.48	19
20	Administrator	1,870	2,120	72,421	34.16	20
21	Assistant Administrator					21
22	Other Administrative	5,695	6,341	76,300	12.03	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,791	3,205	36,974	11.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,629	169,827	$ 2,468,556 *	$ 14.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	monthly	8,400	9, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed charge	5,441	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		248	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,089		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	261	$ 9,898	10, 3	50
51	Licensed Practical Nurses	85	2,206	10, 3	51
52	Nurse Aides	107	1,826	10, 3	52
53	TOTAL (lines 50 - 52)	453	$ 13,930		53

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathy Dyhouse	Administrator	0	$ 72,421
Judith Lowe	Office Manager	0	33,184
Peggy Walker	Bookkeeper	0	32,853
Vanda Walker	Receptionist	0	8,374
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 146,832

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Transworld System Inc.	Collection Fees	$ 625
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 625

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,509
Unemployment Compensation Insurance	23,075
FICA Taxes	179,866
Employee Health Insurance	146,189
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	16,207
Recruiting Fees	11,321
Retirement	5,517
TOTAL (agree to Schedule V, line 22, col.8)	$ 471,684

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,810
(Indicate # of checks performed)	
IL Health Care Assoc Dues	4,444
CLIA User Fee	300
Business License	25
Fox River Activity Prof Assoc Dues	30
Plates for Van	78
Vehicle Sticker Application Fee	15
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,702

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,383
Seminar Expense	2,993
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,376

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lakewood Center # 0037929 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL Health Care Assoc $4444**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,434** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **51,559**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **34**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG Peat Marwick** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Not Yet Available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

LAKEWOOD CENTER
MEDICAID #: 22-3152459001
COST REPORT PERIOD: JAN 1, 2002 - DEC 31, 2002
SPECIAL COST CENTERS
Page 4 - Line 43

	REFER.	COST
Laboratory Fees	V4.4303	7,142
X-Ray Expense	V4.4303	30,791
		37,933

LAKEWOOD CENTER
MEDICAID #: 22-3152459001
COST REPORT PERIOD: JAN 1, 2002 - DEC 31, 2002
MISCELLANEOUS REVENUE

Description	Amount
Current Year Patient Revenue	(266)
Prior Year Patient Revenue	(8,639)
	(8,905)